*Do Not Staple!*

# KENTUCKY EMPLOYEES HEALTH PLAN

## ENROLLMENT APPLICATION FOR THE KENTUCKY RETIREMENT SYSTEMS (KRS)

PY 2009

**Mail application to:**

Perimeter Park West
1260 Louisville Road
Frankfort, KY 40601

**INSURANCE COORDINATOR SECTION**

__ __ / __ __ / __ __ __ __
Coverage Effective Date

8 0 0 0 0 __ __
Company Number Sp Gen HD

**Reason for Application:**

☐ < New Retiree ☐ < Open Enrollment ☐ < QE* ☐ < Previously Waived* ☐ < Other*

* If you previously waived, or marked "Other" or "QE" above, enter the Qualifying Event date AND a description of the Qualifying Event: _____ Date _____ Qualifying Event Description

## SECTION I: DEMOGRAPHIC INFORMATION

Is retiree applying for this coverage? ☐ < Yes ☐ < No

If "No", what is your relationship to the retiree? __ __

__ __ __ – __ __ – __ __ __ __
**RETIREE** SSN *(Required)*

_____
**RETIREE** Name (First, MI, Last)

__ __ __ – __ __ – __ __ __ __
**APPLICANT** SSN (If retiree is not applying)

_____
**APPLICANT** Name (First, MI, Last)

**APPLICANT Specific Information**

_____
Mailing Address

__ __ / __ __ / __ __ __ __
Date of Birth (MM/DD/YYYY)

_____ City, State, Zip Code

_____ County of Residence

_____ Country / Mail Code, if not USA

_____ Planholder's HOME Phone Number

_____ Planholder's WORK Phone Number

_____ Planholder's Email Address

**Smoking Status *(Required)***
Have you smoked in the last 2 months? ☐ < Yes ☐ < No

**Gender**
☐ < Male
☐ < Female

**Marital Status**
☐ < Married
☐ < Single

## SECTION II: PLAN ELECTION- If waiving (i.e. decline) health insurance coverage, go to Section V.

**1. Option** (Check only one)
☐ < Commonwealth Standard PPO
☐ < Commonwealth Capitol Choice
☐ < Commonwealth Optimum PPO

**2. Level of Coverage**
☐ < Single
☐ < Parent Plus
☐ < Couple
☐ < Family

**3. Cross-Reference Payment Option**
(Available for Family Coverage Only)
☐ < Yes
**If Yes, you must complete Sections III and IV**

## SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION → *If you elected Single coverage, skip to Section VII*

| Social Security Number | Name (First, MI, Last) | Gender (Circle one) | Date of Birth (MM/DD/YYYY) | Relationship Code* |
|---|---|---|---|---|
| | | M F | | |
| | | M F | | |
| | | M F | | |
| | | M F | | |

***Relationship Codes: SP = Spouse, CH = Child, DD = Disabled Dependent, CO = Court-Ordered Dependent**

## SECTION IV: CROSS-REFERENCE INFORMATION → *Complete ONLY if you checked Yes in Section II, box 3*

| Your Spouse's Company Number: ***(Required)*** | Dual Employee Indicator, If applicable | Has your spouse smoked in the last 2 months? ***(Required)*** | Is your spouse a Hazardous Duty Retiree? | Your spouse's Hire Date or Retirement Date: |
|---|---|---|---|---|
| _____ | ☐ <Yes | ☐ <Yes ☐ <No | ☐ <Yes ☐ <No | _____ |

PY **2009**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | – | | | – | | | | | |

**Retiree's SSN**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | – | | | – | | | | | |

**Applicant's SSN** (from Page1, Section I)

## SECTION V: WAIVER

Do you wish to waive (i.e. decline) your Health Insurance Coverage? By checking "Yes," I understand that I am declining health insurance coverage through the KEHP for the Plan ☐ < YES

## SECTION VI: FLEXIBLE SPENDING ACCOUNTS (FSA)

**Not Applicable → Retirees are not eligible to participate in a Flexible Spending Account**.

If a retiree elects the cross-reference payment option with an active spouse and the active spouse is eligible and wishes to enroll in the state's Flexible Spending Account Program, the active spouse and the retiree should make their health coverage elections by completing the active employee's Health Insurance Application.

## SECTION VII: AUTHORIZATION AND CERTIFICATION

* I understand that my signature on this application creates a legal and binding contract between myself, the Department of Employee Insurance and the TPA.
* **I understand that if my spouse and I elect the cross-reference payment option, we are dual plan holders and our level of coverage (Family) will automatically drop to a parent plus coverage level upon termination of employment by either spouse/planholder. The cross-reference payment option ceases upon termination of employment by either spouse/planholder.**
* I understand that each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the plan document and in the KEHP handbook.
* I authorize the release of medical claims data to the Kentucky Retirement System for use in data analysis and referral to available health related services upon their review.
* I agree to abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
* I understand that the elections indicated on this application may not be changed during the plan year, with the exception of certain Qualifying Events.
* I authorize the Retirement System to deduct from my retirement benefits the amount required to cover my share of the coverage I have selected.
* I authorize the Retirement System to release the information in this application to the Social Security Administration. The information in this application may be used by the Social Security Administration to determine Medicare eligibility. I further acknowledge that Medicare eligibility may affect my participation in the Kentucky Employees Health Plan.
* I understand that the misrepresentation of any information on this application with the intent to defraud is a fraudulent insurance act, which is a crime, and any material misrepresentation or omission may be used to reduce or deny a claim or to terminate my coverage.
* I understand that this plan has a tobacco incentive for members that do not use tobacco and that this plan offers tobacco cessation programs.
* I have fully read the materials provided to me. My signature below certifies that the statements on this form are true and complete to the best of my knowledge.

| | |
|---|---|
| _____ | _____ |
| Retiree Signature | Date |
| _____ | _____ |
| Applicant Signature (if other than retiree) | Date |
| _____ | _____ |
| Spouse Signature – ***REQUIRED*** **if electing the cross-reference payment option** | Date |
| _____ | _____ |
| Retirement Insurance Coordinator Signature | Date |
| _____ | _____ |
| Spouse's Insurance Coordinator Signature – ***REQUIRED*** **if electing the cross-reference payment option** | Date |